PRIOR AUTHORIZATION REQUEST FORM

Fax completed form and supportive clinical to: **(305) 644-2539**
Behavioral Health Cases should be faxed to: **(305) 644-7734**

MEMBER INFORMATION			
Member Name:		Member Identification Number:	Date:
Member Date Of Birth:		Member Phone Number:	
Member Address:			
REQUESTING PHYSICIAN INFORMATION			
Referring Physician:		Phone Number:	Fax Number:
Referring Physician's Address:		**Referring Physician's Signature/License Number:**	
TIN/NPI:	**Location Code:**		
SERVICING PHYSICIAN/FACILITY INFORMATION			
Servicing Provider Name:		Facility Name:	
Servicing Provider Address:		Facility Address:	
Contact Person:	Specialty:		
Phone Number:	Fax Number:	Phone Number:	Fax Number:
TIN/NPI:	**Location Code:**	**TIN/NPI:**	**Location Code:**

REQUESTED SERVICE/PROCEDURE/COURSE OF TREATMENT	
POS: ☐ Office ☐ Outpatient Center ☐ Outpatient Hospital ☐ Ambulatory Surgical Center ☐ Inpatient Hospital ☐ Inpatient Rehab ☐ SNF/Rehab ☐ Home ☐ Hospice ☐ Inpatient Psychiatric Facility ☐ Other	
If Other, please specify:	
Type of Service or Procedure:	☐ Initial ☐Extension - Previous Authorization #
Quantity or Number of Visits Requested:	

HCPCS/CPT CODES			
Diagnosis ICD 10 Code:	HCPCS/CPT Code:	Code Description:	Medical Reason:

IMPORTANT INFORMATION
Please include/attach clinical/office notes, laboratory information, imaging reports, and any guiding documentation to support medical necessity. If this is an out-of-network request, please provide an explanation.
☐ **Check box if physician believes that waiting for a decision under the standard timeframe could place the enrollee's life, health, orability to regain maximum function in serious jeopardy.**
Telephone: 844-969-5366 - Fax: 305-644-2539 - Behavioral Health Fax: 305-644-7734